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| https://nachccom-5.sharepoint.microsoftonline.com/Communications%20Publishing%20Guide%20and%20Templates/NACHC_LOGO.jpg |  |  |

**Billing for Care Management Services**

 (CMS) Chronic Care Management (CCM) Services

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| **Checklist/Requirements to bill for CCM** | Completed‘***Yes***’ | Missing‘***No***’ |
| **Initiating Visit**. An Evaluation Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) visit furnished by a FQHC employed MD, DO, NP, PA, or CNM. Required of patient not seen within the last year or new patients (not seen in the last three years by a FQHC provider covered by Medicare). Also, the face-to-face visit included in transitional care management (TCM) services (CPT codes 99495 and 99496) qualifies as a “comprehensive” visit for CCM service initiation\* |  |  |
| **Beneficiary Consent**. Obtained during or after the initiating visit and before provision of care coordination services by clinical staff; consent can be written or verbal, but must be documented in the medical record and include: * Availability of care coordination services and applicable cost-sharing
* Advise that only one practitioner can furnish and be paid for care coordination services during a calendar month
* Communicate patient right to stop care coordination services at any time (effective at the end of the calendar month)
* Patient permission to consult with relevant specialists.
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| **Patient Eligibility.** Presence of multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and/or place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline. |  |  |
| **Care Coordination Services**. Documentation of 20 or more minutes of care coordination services furnished in the calendar month (a) under the direction of the FQHC employed practitioner (i.e., MD, DO, NP, PA, CNS or CNM), and (b) by an FQHC practitioner, or by clinical personnel under general supervision. State law, licensure, and scope of practice definitions must be considered for non-primary care service providers. |  |  |
| **Electronic Health Record Documentation**. Structured recording of patient health information using Certified EHR Technology; includes demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care |  |  |
| **24/7 Access**. Patient has 24/7 access to physicians or other qualified health care professionals or clinical staff and means to contact health care professionals in the practice to address urgent needs regardless of the time of day or day of week. |  |  |
| **Continuity of Care**. Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments. |  |  |
| **Comprehensive Assessment**. Comprehensive care management including systematic assessment of the patient’s medical, functional, and psychosocial needs. |  |  |
| **Preventive Care**. System-based approaches to ensure timely receipt of all recommended preventive care services |  |  |
| **Checklist of FQHC Requirements to Bill CMS for CCM** *(page 2 of 2)* | Completed‘***Yes***’ | Missing‘***No***’ |
| **Medication management**. Medication reconciliation with review of adherence and potential interactions; oversight of patient self-management of medications. |  |  |
| **Comprehensive Care Plan**. Comprehensive care plan including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment; and a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed. A comprehensive care plan includes, but is not limited to, the following elements:* Problem list
* Expected outcome and prognosis
* Measurable treatment goals
* Symptom management
* Planned interventions, including responsible individuals
* Medication management
* Community/social services ordered
* A description of how outside services/agencies are directed/coordinated
* Schedule for periodic review and, where appropriate, revision of the care plan
 |  |  |
| **Resources and Support**. An inventory of resources and supports for patients. |  |  |
| **Care Plan Sharing**. Care plan information made available electronically (including fax) in a timely manner within and outside the FQHC as appropriate and a copy of the care plan given to the patient and/or caregiver |  |  |
| **Care Transition Management**. Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; follow-up after hospital discharges from hospitals, skilled nursing facilities, or other health care facilities; and timely creation and exchange/transmission of continuity of care document(s) with other practitioners and providers |  |  |
| **Coordination of Care**. Coordination with home- and community-based clinical service providers, and documentation of communication to and from home- and community-based providers regarding the patient’s psychosocial needs and functional deficits in the patient’s medical record |  |  |
| **Electronic Communication Options**. Enhanced opportunities for the patient and caregiver to communicate with the practitioner regarding the patient’s care through not only telephone access, but also through secure messaging, internet, or other asynchronous non-face-to-face consultation methods. |  |  |
| **Coding & Billing**. Documentation to support using G0511 for General Care Management. Payment for G0511 code may only be billed once per month per beneficiary, and cannot be billed if other care management services are billed for the same time period. |  |  |

\* Providers have to meet the face-to-face service requirements of a TCM visit in order for it to qualify as an initiating visit.

**References**

1. Centers for Medicare and Medicaid Services. Care management in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs, December 2019 accessed at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf>.
2. CMS, Chronic Care Management Services, July 2019. Accessed at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>.
3. FAQ. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf>.
4. CMS, Payment for CCM Services FAQ sheet, accessible at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment_for_CCM_Services_FAQ.pdf>